[COMMITTEE PRINT]

THE HEALTH INSURANCE PROBLEM: ALTERNATIVE STRATEGIES TO EXPAND COVERAGE AMONG SMALL BUSINESSES

COMMITTEE ON SMALL BUSINESS
HOUSE OF REPRESENTATIVES

100th Congress, First Session

DECEMBER 1987

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LETTER OF TRANSMITTAL

DECEMBER 24, 1987.

To All Members of the Committee on Small Business:

I am transmitting a study prepared by the full committee staff entitled "The Health Insurance Problem: Alternative Strategies To Expand Coverage Among Small Businesses."

This report is based on a series of hearings held by the committee this past May and June to examine the problems small businesses face in providing health insurance benefits, and to explore alternative strategies to expand coverage among the Nation's uninsured.

Sincerely,

JOHN J. LAFALCE, *Chairman.*

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I. INTRODUCTION

During the course of the 100th Congress, the Small Business Committee is studying a wide range of public policy issues that directly affect small employers.

The programs and activities of the Small Business Administration (SBA) affect only a fraction of small businesses in this country. Yet, all small firms are affected by a multitude of public policy issues and are faced with difficult and complex problems caused in part by the changing structure of the economy. For this reason, and in order to implement the Committee's special oversight function under the House of Representatives Rule X, (3)(g), Chairman John LaFalce decided that the Committee should play a vigorous role as ombudsman for small business to ensure that their special problems and concerns are fully explored and considered by the Congress.

Toward that end, the Chairman has commissioned several staff reports on issues ranging from liability insurance and the minimum wage increase, to loan asset sales, nonprofit competition, and payroll costs. This report focuses on the problems faced by small businesses in providing health insurance benefits, and alternative strategies to expand coverage among small firms.

Among the pending legislative initiatives that most concern the small business community are proposals to require that all businesses provide certain specified benefits to their employees. Indeed, opposition to mandated employee benefits was the second priority recommendation of the 1986 White House Conference on Small Business.

Congressional attention is now focused on policy options to expand health care coverage among the 37 million Americans who have no health insurance. Attention centers on the mandated health benefits bill that has been introduced in response to the rapid growth in the medically uninsured population. This proposal is intended to build on the existing private health insurance system under which almost 76 percent of the American workforce is insured, directly or indirectly, through employer-based health plans.

The mandated benefits approach to the health insurance problem also reflects the fact that fully two-thirds of the uninsured population are employed adults or their dependents. Since more than half of these workers are either self-employed or work in firms with less than 25 employees, small business has become the principal focus of attention in the health insurance debate.

In addition to the mandated health benefits bill, there are a broad range of less-publicized alternative strategies available to expand health insurance coverage among targeted segments of the uninsured population.

The Small Business Committee conducted a series of hearings in May and June of this year to examine the problems small businesses encounter in providing health care benefits, and to explore alternative options to mandated benefits for expanding coverage among the nation's uninsured. This report discusses these alternatives, and recommends strategies designed to encourage the self-employed to provide health insurance and to remove regulatory obstacles to the formation of pooling arrangements by small businesses.

II. BACKGROUND ON THE PROBLEM AND SUMMARY OF RECOMMENDATIONS

A. The Health Insurance Problem

PROFILE OF THE UNINSURED

Approximately 37 million people have no health insurance coverage from any public or private source. The uninsured population has been increasing at an average rate of over one million a year since 1980, and now totals 17 percent of the nonelderly population in the United States.

Analysis by the Employee Benefit Research Institute of 1985 census data found that almost one-half of the uninsured population are workers (17 million of the 35 million nonagricultural, nonmilitary uninsured). More than 11 million (almost one-third of the total) are children. Only 19 percent are nonworking adults.

Most of the working uninsured population—more than eight million people—are either self-employed or work in firms with less than 25 employees. Over half are employed in the retail trade and services industries. The number of uninsured workers grew by 22 percent between 1982 and 1985, and appears likely to continue to grow rapidly because small firms, and retail trade and service establishments especially, are creating most of the new jobs in this country and generally do not offer health benefits to their employees.

A significant minority of the uninsured are poor. One-third live in families with incomes below the poverty line, and another one-third live in families with income between 100 and 200 percent of the federal poverty standard. Among the working uninsured, three-fourths earn less than $10,000.

PROBLEMS FACED BY SMALL BUSINESS

Small firms are far less likely than larger businesses to provide health insurance coverage. An SBA study found that only 46 percent of businesses with less than 10 employees offer health benefits, compared to over 90 percent of firms with more than 25 workers. High insurance costs, narrow profit margins, and high employee turnover are the main problems faced by small businesses that discourage them from providing health benefits.

According to recent surveys, the principal reason that small businesses do not offer health insurance coverage is that they cannot afford the available insurance products, both because of their firm's low profitability and the high cost of health insurance. Premium costs are higher for small businesses because the risk must be spread over a smaller and more difficult to insure workforce. Small firms employ a disproportionate share of young and old workers, women, and part-time workers, and have a high turn-

over—all factors which increase their insurance costs and act as a disincentive to the purchase of a health insurance plan. The barriers and added costs imposed by government regulation, including lower tax advantages, also act as a disincentive to the small business owner.

HEALTH CARE COSTS

The overall health insurance problem, and the particular difficulties faced by small business in obtaining affordable insurance, is exacerbated by the continuing steep rise in health care costs.

The dimension of the problem is illustrated by the magnitude of total national health spending. In 1986, according to the Health Care Financing Administration (HCFA), public and private health care spending in the United States totaled $458 billion, amounting to 10.9 percent of the gross national product. The nation's health care bill in 1986 equalled $1,837 per person. By comparison, in 1965, health care expenditures amounted to 5.9 percent of GNP and only $205 per person. HCFA projects that the nation's health care bill will reach a 15 percent share of GNP by the year 2000.

Total health spending increased 8.4 percent over 1985, only a slight rise in the 8.1 percent rate the previous year. While the rate of growth has been steadily declining from a high of more than 15 percent in 1980 and 1981, the increase is still far greater then the rate of inflation or the growth of the economy as a whole.

Most of this increase was due to the rise in prices in medical care. Although inflation in other sectors of the economy has slowed considerably in recent years, as reflected by the 1.9 percent increase in the Consumer Price Index in 1986, the rate of inflation in medical care was 7.5 percent.

Public spending accounted for 40 percent of all national health expenditures. Federal outlays were $134.7 billion in calendar year 1986, with Medicare and Medicaid costs accounting for almost 80 percent of the total. Federal health expenditures now equal nearly 12 percent of the budget, and account for fully one-fourth of all federal benefit spending. State and local government health care spending amounted to $55 billion in 1986.

The high cost of health care has resulted in increased health plan costs for employers. The cost of employee health benefits totalled $105 billion in 1986, equal to almost eight percent of payroll costs and amounting to about $1,500 per employee. Large employers are concerned about rising health costs, in part because their premiums are driven even higher due to their subsidizing of insurance coverage for workers in small businesses who are covered by another employed family member. While escalating health costs affect all employers, they result in disproportionately higher costs for small businesses, which traditionally pay 10 to 40 percent more than large firms for health insurance plans.

ACCESS TO HEALTH CARE AMONG THE UNINSURED

People without health insurance generally go without needed health care. Delays in seeking medical treatment often result in a worsening of their health condition, and thus leads to greater medical costs when treatment is finally provided. The lack of health in-

surance especially impedes access to quality health care for the medically indigent.

Few studies exist that analyze problems of access to health care among the nation's uninsured. However, several recent private and government surveys have documented the human costs of the lack of insurance among some segments of the population.

A recent General Accounting Office study, for example, found that nearly two-thirds of pregnant women who either had no health insurance or were on Medicaid obtained insufficient prenatal care. Similarly, according to a 1987 study by the Alan Guttmacher Institute, 555,000 women each year give birth without any health insurance protection. The report found that 1.3 million pregnant women receive insufficient prenatal care. Inadequate medical care during pregnancy is a major cause of premature and low-birthweight babies, and thus contributes to high infant mortality rates. The infant mortality rate in the United States is about 1 percent, or 40,000 infants a year, one of the highest rates of any industrialized country.

Also of growing concern is the number of people who are refused needed medical care because they have no health insurance or other ability to pay for the services. According to a study by the Robert Wood Johnson Foundation, one million people were refused hospital care in 1982 because of their inability to pay for the needed medical services. Patient dumping—the practice of forprofit hospitals transferring patients to public or nonprofit facilities—has become more common in recent years as hospitals face higher costs and lower payments under the Medicare and Medicaid programs. Studies have shown that the condition of patients transferred for economic reasons is often jeopardized by the delay in receiving medical care.

Public hospitals are paying a disproportionate share of all uncompensated hospital care. According to analysis by the Urban Institute and American Hospital Association, forprofit hospitals in the 100 largest metropolitan areas provide only 0.1 percent of the charity care. As forprofit hospitals continue to take over public or nonprofit hospitals, fewer facilities must bear the growing cost of uncompensated care, now estimated at $5 to $8 billion a year.

B. Hearings

The Committee held hearings on the health insurance problem on May 6, June 16 and June 18, 1987. The purpose of the hearings was to outline the dimensions of the uninsured population, to explore the reasons for their lack of health insurance, particularly among employees of small businesses, and to examine various public and private sector options to expand health benefits coverage.

Testimony was heard from a broad spectrum of witnesses with varying perspectives on the problem, including the Small Business Administration, representatives of small business associations, health policy experts, and state officials administering pilot projects to expand health care for the uninsured.

The witness list follows:

May 6, 1987

Frank S. Swain, Chief Counsel for Advocacy, U.S. Small Business Administration.

Frederic M. Rohm, President, New Castle County, Delaware Chamber of Commerce; Member, Health Care Council, U.S. Chamber of Commerce.

Deborah Chollet, Senior Research Associate, Employee Benefit Research Institute.

Karen Williams, Director of Research and Policy Development, Health Insurance Association of America.

June 16, 1987

John J. Motley III, Director, Federal Government Relations, National Federation of Independent Business.

John J. Polk, Executive Director, Council of Smaller Enterprises; Vice President, Greater Cleveland Growth Association; Member, National Small Business United.

Frederick D. Hunt, Jr., President, Society of Professional Benefit Administrators.

Gail R. Wilensky, Vice President of Health Affairs, Project HOPE.

June 18, 1987

W. David Helms, Executive Director, The Alpha Center for Health Policy and Planning; Senior Program Consultant, Health Care for the Uninsured Program, The Robert Wood Johnson Foundation.

Leonard Kirschner, M.D., Director, Arizona Health Care Cost Containment System.

Gail Silverstein, Project Director, Health Care Group, Arizona Health Care Cost Containment System.

Judith Glazner, Project Director, Shared Cost Option for Private Employers, Denver Department of Health, Denver, Colorado.

Larry A. Thompson, Executive Director, Puget Sound Health Systems Agency, Washington; Project Director, Project Access.

David R. Riemer, Counsel for Cost Containment, Time Insurance Company, Milwaukee, Wisconsin; Member, Council on Health Care Coverage for the Uninsured, Wisconsin Department of Health and Social Services.

In addition, statements for the record were submitted by Francis R. Carroll, President, Small Business Service Bureau, Inc., and Uwe E. Reinhardt, James Madison Professor of Political Economy, Princeton University.

C. Options To Expand Coverage

TAX INCENTIVES

One important tax incentive suggested by many of the witnesses concerned the tax deduction for health insurance costs of the self-employed (owners of unincorporated businesses). The self-employed are treated differently than their corporate counterparts in the taxation of their insurance premiums. Incorporated businesses are entitled to deduct the full cost of their health premium costs, while

the self-employed may only deduct 25 percent beginning in 1987. Increasing the deduction to 100 percent would rectify this inequity in the tax code and would create an incentive for the self-employed to provide health insurance for themselves and their employees.

INDUSTRY POOLING ARRANGEMENTS

Industry pooling arrangements, such as Multiple Employer Trusts (METs), are designed to reduce health insurance costs for small businesses by standardizing policies and centralizing administration in order to achieve economies of scale and rating stability. METs are a principal strategy for encouraging small employers to provide health insurance coverage.

A number of the Committee's witnesses pointed out, however, that the formation of these pooling mechanisms are discouraged by existing government regulations, such as ERISA restrictions and state mandated benefit laws. These regulatory obstacles could be largely overcome, according to the witnesses, by amending ERISA to exempt all insurance plans from state regulation and by allowing all association plans to self-insure, rather than only those composed of businesses of a similar nature.

SUBSIDIZED RISK POOLS

State risk pools have been established in fifteen states to sell health insurance at a subsidized rate to individuals who do not have access to employer-sponsored health benefits or have been denied coverage because of a preexisting medical condition. Another option is to expand these risk pools to provide insurance for low-income workers, and for medically-uninsurable employees whose presence prevents their employer from obtaining group health coverage.

Witnesses emphasized that the funding of state risk pools must be as broad-based as possible. Currently, most pools are funded by a tax on insurers. Legislation has been proposed that would enable states to also tax self-insured plans, and to require that all employers with 20 or more workers underwrite such funds. The Omnibus Budget Reconciliation Act for FY 1988 (H.R. 3545), as passed by the House, included a provision to require all employers with 20 or more employees to participate in their state's health insurance pools. That provision was not included in the final version of the bill.

MEDICAID BUY-INS

The principal policy option to extend health care coverage to the poor unemployed and to low-income workers involves expanding the current Medicaid program in two ways: (1) by expanding the income eligibility levels to cover significantly more of the poor population; and (2) by allowing the near poor and low-income workers, and certain small businesses, to buy into Medicaid with premiums adjusted on an income-based sliding scale.

Several bills have been introduced in the House and Senate to expand Medicaid, including the Welfare Reform bill (H.R 1720) passed by the House, which requires states to extend Medicaid cov-

erage for twenty-four months to families who lose coverage because a parent takes a job.

SUBSIDIZED VOUCHER/TAX CREDIT

A public sector strategy to expand coverage among the low-income uninsured, currently being tested by several states, is to provide a direct state government subsidy toward the purchase of adequate health insurance. The subsidy could take the form of a tax credit or a redeemable voucher, and could be made available to all those uninsured whose incomes are below some threshold level, such as 200 percent of the federal poverty standard.

COST CONTAINMENT STRATEGIES

In response to the lack of affordable health plans for small businesses, some states and private insurers are exploring the feasibility of creating low-cost insurance products that feature various cost containment mechanisms. Such programs may establish managed health care systems, for example, that use existing HMOs and other group health care providers in a plan designed to control health care access and utilization. Another proposal is to establish a catastrophic health plan to provide minimal coverage at a reasonable cost. The basic features of such a plan would include low premiums, very high deductibles, coverage of specified core benefits, and a limit on out-of-pocket expenses to protect against the cost of catastrophic illness.

EDUCATIONAL EFFORTS

Small businesses generally do not have the personnel or the needed expertise to investigate the health insurance market and decide among alternative plans. Providing information on available health insurance plans, establishing insurance referral services, and similar educational efforts are intended to overcome the basic lack of knowledge and information among most small business owners regarding available health care plans and how to obtain insurance coverage at a reasonable price.

MANDATORY EMPLOYER-BASED INSURANCE

In order to assure that all workers will have access to health insurance, legislation has been introduced to require that all employers provide a basic minimum package of health insurance coverage for their employees. Under the mandated health benefits bill introduced by Senator Kennedy (S. 2165), employers would be required to pay at least 80 percent of the cost of insurance. Small firms with less than 25 workers would be aggregated into larger insurance units to obtain the benefits of community rating, group purchasing power, and lower administrative costs.

D. Summary of Recommendations

This report recommends the following alternative strategies to expand coverage among small businesses by providing a tax incentive for the self-employed, and by changing government regulations to encourage small firms to form pooling arrangements. These

strategies could be implemented almost immediately to begin to fill the gaps in health insurance coverage. Other public and private sector strategies now being tested in state pilot projects should be evaluated at the appropriate time to determine their feasibility at the federal level.

1. FULL TAX DEDUCTION FOR SELF-EMPLOYED

Chairman LaFalce has introduced legislation (H.R. 3065) to increase the income tax deduction on health premiums for the self-employed from 25 percent to 100 percent. This will provide an incentive for unincorporated business owners to provide health insurance coverage for themselves and their employees.

2. ENCOURAGE POOLING ARRANGEMENTS

The smallest businesses, those with less than 25 employees, need to join together into larger groups to obtain affordable health insurance. The committees of relevant jurisdiction are urged to explore possible solutions to the regulatory obstacles imposed by ERISA and the Tax Code that discourage the formation of such pooling arrangements. Specifically, it is recommended that ERISA be amended to permit small group associations to self-insure, and thus be exempt from state mandated benefit laws.

3. SUBSIDIZED RISK POOLS

State risk pools, subsidized by insurers and employers, are established to provide insurance for the medically uninsurable. In order to facilitate the establishment of such risk pools by providing more broad-based funding, it is recommended that legislation be enacted, as proposed by Representative Stark, to require employers to participate in risk pools and to enable states to tax self-insured plans.

III. THE PROBLEM

The number of Americans without health insurance has been increasing dramatically in recent years. In 1985, nearly 37 million people under age 65 had no health insurance from any source, public or private. The uninsured population grew by 15 percent between 1982 and 1985, and appears to be increasing rapidly. People who have no health insurance coverage now total 17 percent of the nonelderly population in the United States. Approximately 70 percent of the uninsured are employed adults or their dependents. More than half of the working uninsured are either self-employed or work in businesses with less than 25 employees.

There are a variety of reasons why individuals do not have health insurance. In addition to the working uninsured whose employers do not offer health benefits, the uninsured include the poor or near-poor who do not qualify for Medicaid; those who are unable to obtain insurance due to their medical condition; and some individuals—mostly younger and healthier persons—who simply choose not to have health insurance.

This report focuses primarily on the medically uninsured worker and discussses the reasons why small employers are far less likely to offer health benefits than larger businesses. The main factors contributing to the lack of coverage among small firms are the disproportionately higher cost of health insurance for small employers, the barriers and disincentives caused by government regulation, and the lack of availability of an insurance plan for the very small business market.

A. The Uninsured Population

During the Committee's hearings, Ms. Deborah Chollet of the Employee Benefits Research Institute (EBRI) and Mr. Frank Swain of the Office of Advocacy in the Small Business Administration (SBA) presented survey results describing the characteristics of the nation's uninsured population. EBRI's estimates of the uninsured population are based on the March 1986 Current Population Surveys conducted by the Bureau of the Census. SBA's data are based on an August 1986 survey which focused on the differences in health benefits availability across firm size and industry.

EBRI's analysis details the characteristics of the nonagricultural, nonmilitary population under age 65 who reported no health insurance coverage of any type for some part of 1985—nearly 35 million people. Following is a summary of that analysis:

Employment Status.—Nearly one-half of the uninsured population (49 percent, or 17 million people) are workers (chart 1). The number of workers without health insurance has grown by more than 22 percent since 1982. Uninsured workers now total almost 20 percent of the entire workforce. Health economists attribute this

increase in the number of uninsured workers to two factors: the rapid growth of employment in small firms, which are far less likely to offer health benefits, and the redistribution of workers toward industries that historically have lower rates of health care coverage: retail trade, nonprofessional services, and construction.

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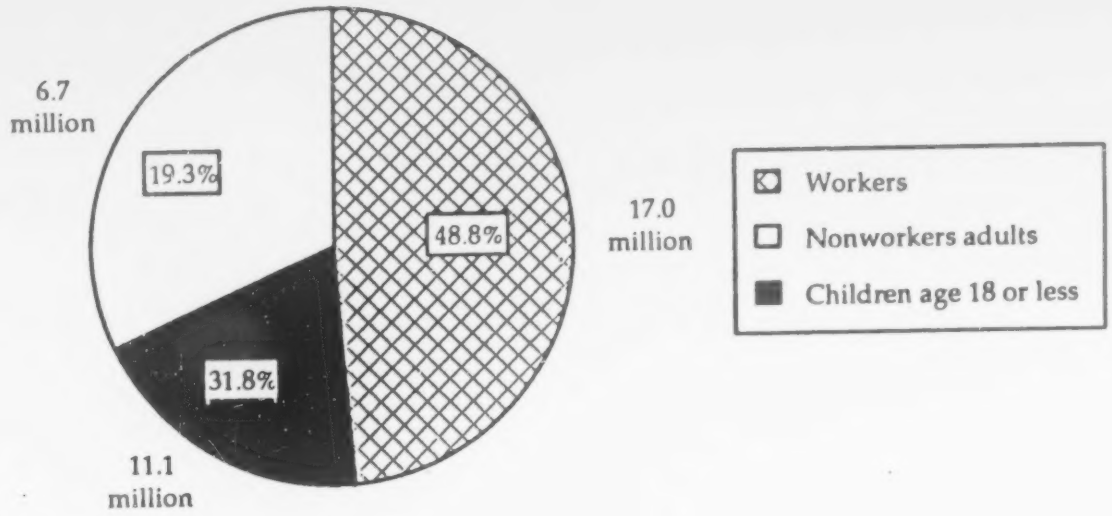
Chart 1

Nonelderly Population without Health Insurance Coverage by Own Work Status, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

The rapid growth of jobs in small firms has been widely documented. Economist David Birch of the Massachusetts Institute of Technology, for example, has found that businesses with less than 100 employees created two-thirds of the net new jobs over the past decade. Dun & Bradstreet has estimated that firms with less than 50 workers will account for nearly half of the 2.6 million jobs expected to be created in 1987.

A majority of these new jobs are in very small businesses which can least afford employee benefits, or in the retail trade and services industries which are the least likely to offer health insurance coverage.

According to EBRI, the rate of health insurance coverage among employees of very small firms (under 25 workers) is less than half the rate among workers in larger firms. In 1983 (the most recent year for which Census Bureau data is available), for example, only 37 percent of workers in firms with less than 25 employees had employer-based health insurance coverage, compared to 66 percent in firms with 25 to 100 workers, and 85 percent in firms with 1,000 or more employees (table 1).

TABLE 1.—CIVILIAN WORKERS BY PARTICIPATION IN AN EMPLOYER-BASED HEALTH INSURANCE PLAN AND FIRM SIZE, 1983

[Numbers in millions]

Firm size	Total	Participants			Nonparticipants[1]		
		Number of workers	Percent of workers within firm size	Percent of all participants	Number of workers	Percent of workers within firms size	Percent of all nonparticipants
Total [2]	85.3	51.3	60.1	100.0	34.0	39.9	100.0
Self-employed	9.1	0.1	1.3	0.2	9.0	98.7	26.5
Under 25	21.2	7.7	36.2	15.0	13.5	63.8	39.7
25 to 99	10.2	6.7	65.4	13.0	3.5	34.6	10.4
100 to 499	10.8	8.1	75.1	15.8	2.7	24.9	7.9
500 to 999	4.4	3.5	79.9	6.9	0.9	20.1	2.6
1000 or more	29.5	25.2	85.3	49.1	4.3	14.7	12.8

[1] Includes those who reported that they did not know if they were included in their employer's health insurance plan.
[2] Total excludes 13.7 million workers who reported that they did not know their firm's size.

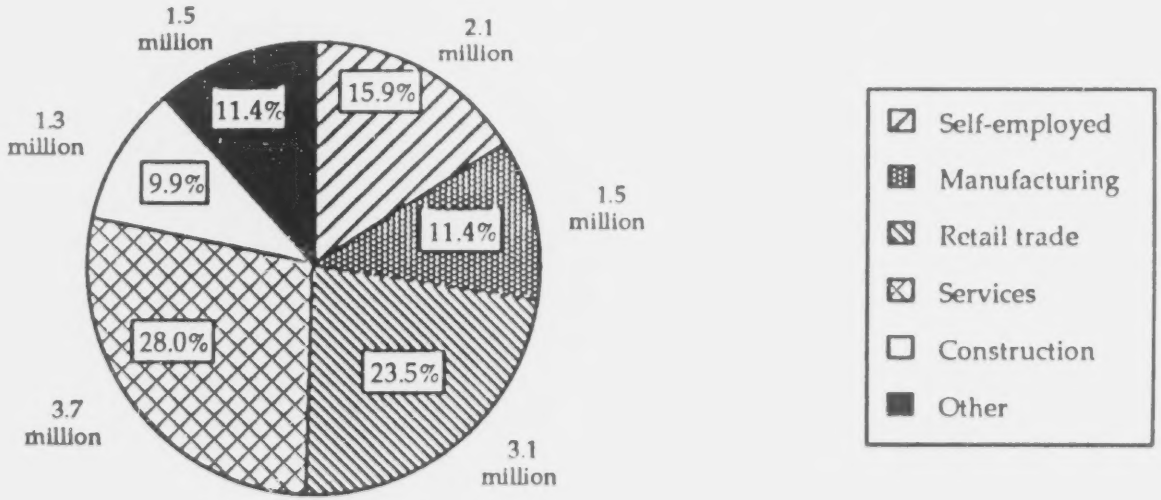
Source: Employee Benefit Research Institute tabulations of the May 1983 Current Population Survey.

Similarly, according to the 1986 SBA survey, nearly half of all uninsured workers are in firms with less than 25 employees. In contrast, in firms with 25 or more employees, over 90 percent of the employers offer health benefits to their workers.

More than half of all uninsured workers are employed in the retail trade and services industries (chart 2). Between 1980 and 1985, employment in these industries and in the construction industry grew by approximately 17 percent, four times as fast as employment in industries with higher rates of coverage. In 1985, these low-coverage industries accounted for 35 percent of total employment, compared to 30 percent in 1982.

Chart 2

Full-Year Workers Age 18–64 without Health Insurance Coverage by Industry of Primary Employment, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

The rate of noncoverage among workers in retail trade was 23 percent in 1985. In the nonprofessional services industry, the rate was 32 percent, and among workers in the construction industry, it was 24 percent (table 2).

TABLE 2.—WORKERS AGE 18–64 BY SELECTED SOURCES OF COVERAGE AND INDUSTRY OF PRIMARY EMPLOYMENT, 1985

	Total (millions)	Employer-based coverage (percent)			No coverage	
		Total	Direct	Indirect	Millions	Percent
Total	112.4	75.6	60.8	14.8	16.6	14.8
Self-employed	9.7	51.5	28.9	21.6	2.3	23.7
Mining	1.1	81.8	81.8	(1)	0.1	9.1
Construction	6.3	66.7	55.6	11.1	1.5	23.8
Manufacturing	21.9	88.1	81.7	6.4	1.9	8.7
Transportation, communication and other public utilities	7.6	86.8	80.3	6.6	0.6	7.9
Wholesale trade	4.1	82.9	73.2	9.8	0.4	9.8
Retail trade	17.6	63.6	39.8	23.9	4.1	23.3
Finance, insurance and real estate	6.6	86.4	72.7	13.6	0.5	7.6
Business and repair services	5.3	66.0	49.1	17.0	1.2	22.6
Personal services	3.7	48.6	27.0	21.6	1.2	32.4
Entertainment and recreation services	1.3	53.8	30.8	23.1	0.3	23.1
Professional and related services	21.9	81.7	63.9	17.8	2.2	10.0
Public administration	5.4	88.9	79.6	9.3	0.3	5.6

[1] Number too small to be statistically reliable.

Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Another 16 percent of all uninsured workers are self-employed. That total (more than two million people) amounts to nearly one-fourth of all self-employed individuals in 1985.

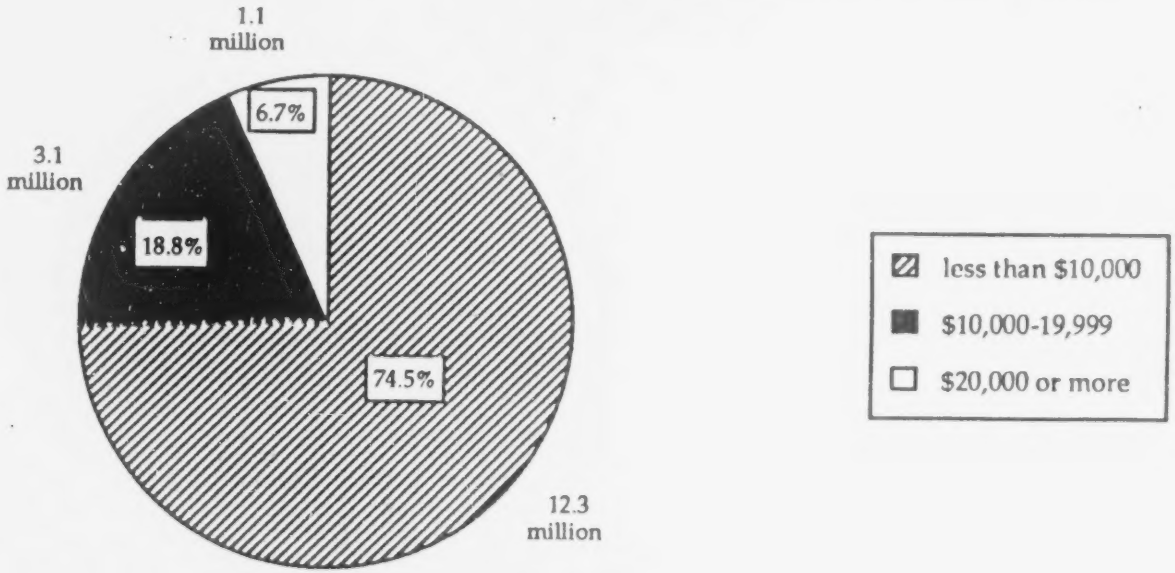
Only 19 percent of the uninsured are nonworking adults, defined by EBRI as people over age 18 who neither worked nor looked for work during the year.

Among the nearly 76 percent of all workers who are insured, about 61 percent are covered directly by their own employer, and the remaining 15 percent are covered by the policy of another employed family member. This indirect coverage is most prevalent in the retail trade and services industry (table 2).

Income.—Most workers who lack health insurance coverage have relatively low earnings. In 1985, three-fourths of all uninsured workers earned less than $10,000; more than one-third earned less than the minimum wage. Nearly all (93 percent) earned less than $20,000 (chart 3).

Chart 3

Workers Age 18–64 without Health Insurance Coverage by Personal Earnings, 1985

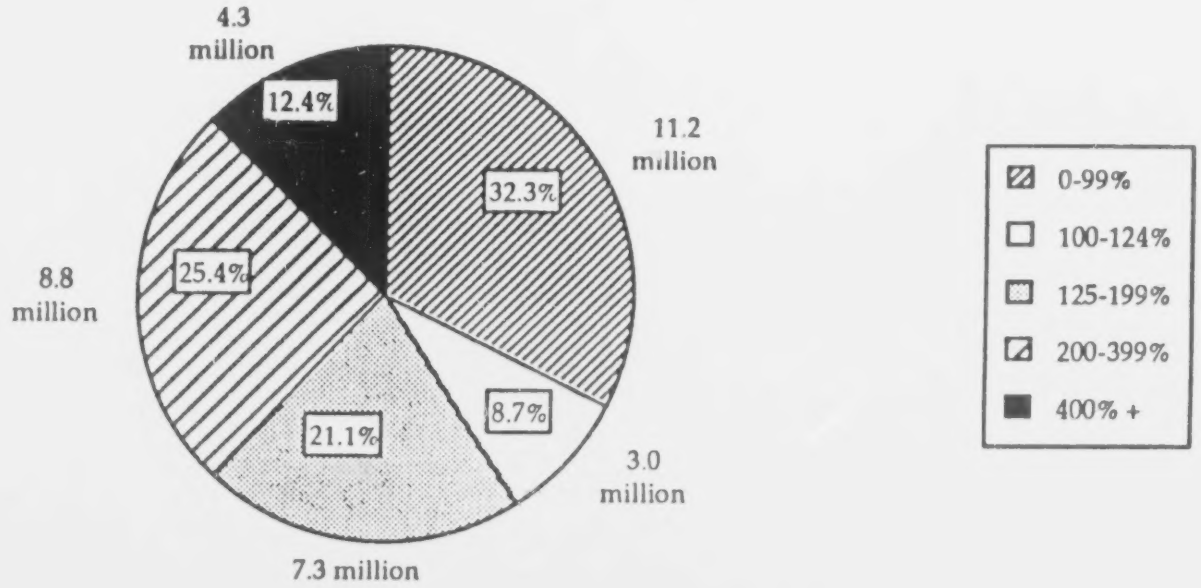


Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Among the total uninsured population, one-third lived in families with income below the federal poverty line, and another one-third lived in families with income between 100 and 200 percent of the poverty level (chart 4). (The federal poverty standard for a family of two in 1985 was $7,230; for a family of four, $10,990.)

Chart 4

Nonelderly Population without Health Insurance Coverage by Family Income As a Percent of Poverty, 1985



Source: Employee Benefit Research Institute tabulations of the March 1986 Current Population Survey.

Family Characteristics.—More than half (52 percent) of the uninsured population lived in families of full-time, full-year workers. Only 17 percent lived in families headed by part-time or part-year workers, and another 14 percent lived in families headed by a nonworker. The remaining 17 percent lived with a full-year worker that was employed for some time during the year. (Note: EBRI defines a full-year worker as steadily employed or sometime-unemployed workers who worked or sought work for 35 weeks or more during the year. Part-year workers include all those who worked or sought work fewer than 35 weeks during the year.)

Demographics.—Nearly one-third of those without health insurance, about 11 million people, are children age 18 or younger. Thirty-nine percent of these uninsured children live in poverty, and half of these live in families headed by a woman not living with a spouse. Twenty percent lived with a parent who had health coverage from an employer plan. Chollet reported that there are no data to indicate whether the insured worker's plan did not offer dependent coverage, or whether it was available but the worker did not take it.

More than half (53 percent) of the uninsured workers are under age 25, and more than two-thirds (69 percent) are under age 30.

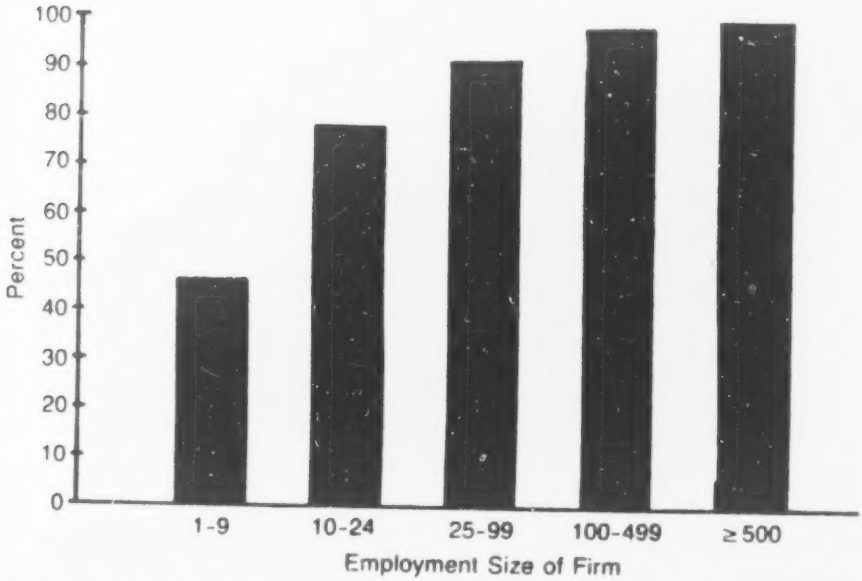
The rates of noncoverage among men and women workers is essentially the same: 15 percent among all employed men and 14 percent among women.

The rates of noncoverage vary substantially among the states. States characterized by high unemployment or low rates of employer health insurance coverage (e.g., Arkansas, New Mexico, Oklahoma, and Florida) and/or low rates of Medicaid coverage (e.g., Louisiana) have populations with particularly high proportions of uninsured people. In 14 states (mostly in the South) and the District of Columbia, 20 percent or more of the nonelderly population was uninsured. By comparison, states in New England, the Mid-Atlantic, and Midwest regions averaged 12 to 14 percent. In Connecticut and Wisconsin, less than 10 percent of the population had no health insurance.

Firm Characteristics.—Large businesses, those with more than 100 employees, almost universally offer health insurance coverage, while the smallest firms, those with less than 10 employees, are least likely to provide health benefits. According to SBA's analysis, only 46 percent of businesses with under 10 employees provide health coverage, compared to 78 percent of firms with 10–24 workers, and 92 percent of firms with 25–99 employees (chart 5).

Chart 5

Firms that Offer Health Benefits, 1985



Source: U.S. Small Business Administration, Office of Advocacy, ICF Report (1986).

SBA's analysis also indicated that the type of ownership is an important factor in determining whether or not a business will offer health insurance. Among sole proprietorships, for example, only 29 percent of those with less than 10 employees offer coverage, compared to 70 percent of all corporations with less than 10 employees. Even in firms with 25–99 employees, only 44 percent of sole proprietorships provide health benefits, while 92 percent of all firms of that size do so (table 3).

One major reason for this lack of coverage is the fact that owners of unincorporated businesses were unable to deduct their health insurance premiums, while owners of corporations are entitled to a full tax deduction. (The Tax Reform Act of 1986 now allows a 25 percent deduction for unincorporated business owners, beginning in 1987 and ending in 1990.)

In terms of industry, SBA's survey found that the firms least likely to provide health insurance coverage are those in retail trade and construction. Only 32 percent of retail trade firms and 51 percent of construction firms offer health benefits. A higher percentage (67 percent) of firms in the services industry provide coverage, although that industry accounts for a large portion of the uninsured workers (table 3). As Swain noted in his testimony, these three industries are characterized by lower and variable profits, frequent employee turnover, and a high number of part-time, seasonal, or young workers.

TABLE 3.—FIRMS THAT SPONSOR HEALTH PLANS BY SIZE AND SELECTED CHARACTERISTICS, 1986 [1]

[In percent]

	All firms	Employment size of firm						
		1 to 9	10 to 24	25 to 99	100 to 499	500 +	< 100	100 +
10 years or less	44	38	64	96	94	100	44	95
More than 10 years	63	51	82	90	99	100	62	99
Construction	51	45	67	93	100	100	51	100
Manufacturing	73	60	81	98	100	100	72	100
Wholesale	78	74	87	90	100	100	77	100
Retail	32	21	59	94	96	100	31	96
Finance, insurance, real estate	71	64	89	94	96	100	70	97
Services	67	59	95	85	97	100	66	98
Sole proprietorship	29	29	30	44	84	100	29	85
Corporation	77	70	82	96	100	100	76	100
Subchapter S corporation	49	31	85	88	100	93	48	99

[1] Not included in this table are firms in the transportation, agriculture, and mining industries, which were grouped together in the study in a residual category.

Source: U.S. Small Business Administration, Office of Advocacy, ICF tabulations of the Health Benefits Data Base, 1986.

Older, established firms are more likely to offer health benefits than businesses that have been in existence for only a few years. According to SBA, 63 percent of firms that have been in business for more than 10 years provide health insurance, compared to 44 percent of firms that are less than 10 years old (table 3).

B. Problems Faced by Small Business

In surveys conducted by the Small Business Administration, the National Federation of Independent Business, the insurance industry, and others, the most common reasons given by employers for not offering health insurance coverage is their inability to afford the available insurance products, due to their firm's insufficient profitability and the high cost of insurance (table 4). A second—and very important—reason are the barriers and disincentives caused by government regulation. The lack of an insurance product for the very small business market (firms with less than 10 employees) is also a serious problem.

1. HEALTH INSURANCE COSTS

The cost of health care has been increasing at a rate far greater than the rate of inflation over the past five years. According to the Health Care Financing Administration, medical care prices increased 7.5 percent in 1986, compared to a 1.9 percent increase in the overall Consumer Price Index. Total public and private health care expenditures amounted to $458 billion last year, equal to nearly 11 percent of the Gross National Product. Of that amount, about $105 billion can be attributed to the cost of health insurance benefits paid by employers.

The continuing steep rise in health care costs is of particular concern to small businesses because they traditionally pay higher insurance rates than larger firms. As Swain noted in his testimony, health insurance rates for small businesses are 10 to 15 percent higher than for large businesses. In 1986, according to SBA's

TABLE 4.—FIRMS NOT OFFERING HEALTH INSURANCE COVERAGE BY FIRM SIZE AND EMPLOYER REASON, 1986

(In percent [1])

Reason given by employers for not offering coverage	All firms	Employment size of firm				
		1 to 9	10 to 24	25 to 99	100 to 499	100 + [2]
Insufficient profits [3]	67	68	62	54	67	36
Insurance costs too high	62	61	70	41	62	68
Worker turnover too high	19	17	31	26	18	83
Group coverage not available	16	17	3	22	16	0
Lack of interest	13	13	6	5	13	0
Administrative costs too high	9	10	2	0	9	51
State minimum coverage regulations too restrictive	1	1	0	0	1	0
Other	9	8	21	5	9	54

[1] Responses sum to more than 100 percent for multiple reasons.
[2] Because virtually all firms with more than 500 employees offer health insurance, the 500 + size group has been combined with 100 to 499.
[3] Insufficient profits may be a proxy for high insurance costs and may reflect the lack of options available to small employers to reduce these costs.

Source: U.S. Business Administration, Office of Advocacy, ICF tabulations of SBA Health Benefits Data Base, 1986.

survey, average monthly premiums for firms with less than 100 percent were $85 for single coverage and $205 for family coverage, compared to $77 and $181, respectively, for firms with more than 100 workers. Similarly, an analysis by the Health Insurance Association of America estimated the premium difference to range from 20 to 30 percent.

There was general agreement among the witnesses who testified before the Committee that the major factors contributing to these higher premium costs for small firms are first, higher acquisition costs and administrative expenses; and secondly, worker characteristics and the behavior of small businesses in the marketplace.

Acquisition Costs and Administrative Expenses

The primary reason for higher premiums for small businesses is higher acquisition costs and fixed administrative expenses. These expenses increase premium costs for small employers because they are higher in absolute terms, and they must be recovered from a smaller number of employees.

Karen Williams of the Health Insurance Association of America (HIAA), in her testimony before the Committee, described the acquisition and administrative expenses incurred by the insurer in providing coverage to small employers.

Acquisition costs, such as marketing and underwriting, account for most of the difference between large and small group premiums, according to HIAA's analysis. Marketing costs are higher simply because fewer small businesses actually purchase coverage, and because such costs are incurred repeatedly due to the low renewal rate among small firms.

Insurers also incur the additional expense of individual underwriting, i.e., gathering and analyzing information on the health status of all employees who will be covered, in order to determine the premium for small employers. If one or more workers has a chronic illness or is in poor health, the firm may be denied coverage or the premiums will be set very high because the risk of high medical costs must spread over a relatively small group. Such indi-

vidual underwriting is not necessary for large businesses because the insurer's risk is spread over a much larger number of employees.

HIAA's analysis concluded that two types of administrative expenses are fairly constant across different insured plans regardless of the size of the employer. These are state premium taxes, which range from zero to over 4 percent, and the expense of claims administration, which is a relatively constant 4 to 5 percent of premiums.

Williams noted that there are also numerous overhead expenses of the insurer which are generally higher for small groups. These include the cost of complying with state legal and regulatory requirements; billing, collection, and accounting of premiums; maintenance of accounts and reserves; and tracking of the enrollment status of the firm's employees.

In addition to the increased costs to the insurer, the administrative costs incurred by small employers in purchasing a health insurance plan are disproportionately higher. As Swain pointed out, small employers cannot afford to invest the time and money necessary to investigate health care costs and alternative delivery systems, nor can they afford to hire benefits counselors to assist workers, follow health regulations, or implement cost containment measures. According to the SBA survey, about two-thirds of small firms have traditional indemnity insurance plans, and thus have little flexibility to control costs. Moreover, few small businesses can afford to self-insure, an alternative favored by larger businesses as a way of lowering costs.

Swain also noted that health insurance plans are more expensive for small employers because they generally pay all of the premium costs, rather than require an employee contribution. His survey found that 70 percent of firms with less than 100 workers pay all of their employees' premium costs, compared to 61 percent of firms with 100 or more workers. Swain suggested that the reasons small businesses are more likely to pay the full premium may be because it is less of an administrative burden to do so, or because they wish to compensate for fewer employee fringe benefits overall.

Worker Characteristics and Small Business Market Behavior

Other factors which result in high health insurance costs for small businesses relate to the characteristics of small firm employees and the behavior of the small employer in the marketplace. The primary problems are adverse selection (the purchase of insurance mainly by high health care users), practiced by both the small employer and the employees, low renewal rates, and high worker turnover.

As described by Williams, adverse selection occurs when a small employer is motivated to purchase health insurance coverage because of a current need for health care services by the employer, family members, or a key employee. If these health risks are not discovered in the underwriting process, the premium collected is likely to be insufficient to cover the cost of claims.

Likewise, employees can be expected to enroll in the health plan based on their own health care needs and that of their family. Thus, the younger and healthier workers may often decline cover-

age, while the older and less healthy workers are more likely to purchase coverage to protect themselves and their families. This is a particularly acute problem in small businesses because they tend to employ a higher percentage of both young and old workers.

The prevalence of low-wage earners in small firms also contributes to the adverse selection problem. They may turn down health coverage in preference for a higher wage, or if they do elect coverage, they may often pose a higher risk to the insurer because of poor or inadequate health care in the past.

To counter this adverse selection, as Williams noted, "(The) insurers only recourse is to decline to issue coverage to a group where less than 75 percent of the employees agree to make premium contributions otherwise required by their employer."

When adverse selection results in a higher than anticipated level of health claims, the premiums are adjusted upward. Higher premiums discourage employees with limited health care needs from purchasing or continuing coverage. An "antiselection spiral" is thus set in motion as fewer and fewer employees are willing to purchase health coverage at higher and higher rates.

The increased premium levels also result in low renewal rates as the employer with higher claims will switch coverage if he can appear to a different insurer to present a predictable and relatively low risk. Also, the employer may drop coverage altogether if the original need for health care on the part of the employer or family member no longer exists.

Another factor contributing to nonrenewal is the relative financial instability of many small businesses. Profit margins are minimal and bankruptcy rates are extremely high. As Williams stated, "In such an environment, insurers must often struggle to collect premiums on a regular basis and to retain those employers whose claims costs did not indicate a compelling and immediate need for continued coverage." According to the Blue Cross and Blue Shield Association, it is not uncommon to find that one-third of small firms enrolled with an insurer leave each year.

The characteristic high turnover rate of employees in small businesses also contributes to the high cost of health insurance. A greater percentage of part-time or seasonal employees also increases costs since such workers are just as expensive to insure as full-time employees.

2. GOVERNMENT REGULATION

A number of state and federal government regulations act as barriers or disincentives to small employers who might otherwise offer health benefits to their workers. These regulations not only contribute to the high cost of health insurance, but discourage employers from purchasing insurance because of their complexity and burdensome reporting requirements. In particular, the committee's witnesses strongly opposed state mandated benefit laws, the inequitable tax treatment of health insurance premiums paid by unincorporated businesses, and the continuation of health coverage provisions under the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA).

Tax Disincentive

The Federal Tax Code imposes a disincentive for the self-employed and unincorporated business owners to provide health insurance for themselves and their employees. They are allowed only a 25 percent tax deduction on their health insurance premiums, compared to a full 100 percent tax deduction for owners of incorporated businesses.

As the law existed prior to 1987, self-employed business owners were allowed no tax deduction for the cost of their health insurance premiums. The Tax Reform Act of 1986 began to rectify this inequity in the Tax Code by permitting a 25 percent deduction, but only for a 3-year period. The deduction is allowed only if the self-employed offer comparable health benefits to their employees.

The impact of this unequal tax treatment of health insurance premiums on the incidence of employer-sponsored health coverage is shown in the SBA survey, which found that the legal form of a business is an important determining factor in the offering of health benefits. As noted previously, only 29 percent of sole proprietorships offer health coverage, compared to 49 percent of Subchapter S corporations, and 77 percent of corporations. Even among firms of less than 10 employees, corporations are more than twice as likely to provide health benefits than a sole proprietorship or Subchapter S corporation.

State Mandated Benefits

All 50 states have laws requiring that certain specific health benefits be included in all insured employee health plans, or be made available by insurers. Most state mandated benefit laws do not establish minimum standards for health benefit plans, but rather require coverage of specific illnesses or treatment methods, and payment for services by certain health professionals and institutions that may not typically be included in many health insurance packages. For example, most mandated benefit laws require health plans to cover treatment for alcoholism, for the mentally or physically handicapped, for mental illness, and reimbursement for treatment by chiropractors or psychologists. Many state mandates also require continuation of coverage for employees who may be laid off, and their dependents, or for the widowed spouses of deceased workers.

Such mandated benefits increase administrative costs of insurers and the cost of health plans themselves, thereby acting as a further disincentive to employers who might otherwise provide health coverage to their employees. Mandated benefits not only preclude small business owners from purchasing a minimum health plan that they might be able to afford, but also may cause employers to drop the basic employee coverage they already have.

The National Association of Insurance Commissioners, in a 1986 report, described the problems caused by state mandates:

> Mandated health benefit plan legislation may add to the cost of insurance coverage, thereby adding to the affordability problems for many. Such legislation often frustrates health care cost containment and deprives consumers of deciding which coverages are most appropriate and affordable to them . . . (and) added costs of administration result from the need to prepare and file multiple policy forms conforming to diverse requirements of the various states.

Congress had intended to supercede the conflicting state laws mandating different benefit levels and reimbursement rules for insured plans when it enacted the Employee Retirement Income Security Act of 1974 (ERISA). That law preempts state laws that relate to employee pension and welfare benefit plans, and sets minimum standards that such benefit plans must meet.

However, a U.S. Supreme Court decision in 1985 *(Metropolitan Life Insurance Co. v. Massachusetts)* held that ERISA does not preempt state laws affecting insured welfare benefit plans. The court cited the McCarran-Ferguson Act of 1945, which authorized the states to regulate the insurance industry, and ruled that the states' right to regulate insurance outweighs the ERISA preemption.

ERISA still protects self-insured plans from any state mandated benefits. Self-insured (or self-funded) plans are those in which the employer assumes the risk for paying claims instead of transferring the risk to an insurance carrier. (Some employers, particularly smaller firms, may limit their plan's liability by purchasing "stop-loss" insurance to cover catastrophic expenses above a maximum amount.) A major consequence of the *Metropolitan* decision has been that large businesses, and even some firms with less than 50 employees, elect to self-insure so that they can better control costs by devising their own health benefits package free of any state mandates. It is estimated that between 25 and 40 percent of group benefits are now self-insured.

The trend toward self-insured plans exacerbates the problems that small businesses face in obtaining affordable health benefits coverage. The growth in self-insured employer health plans serves to increase the cost of health plans offered by private insurers. As more and more workers are removed from the total pool of privately insured persons in a given geographical area, the insurance carriers have fewer people over whom to spread the risk of health care costs. Hence, higher insurance premiums, particularly to small businesses.

COBRA's Continuation of Coverage Provisions

Another obstacle or disincentive to health care coverage caused by federal regulation is the continuation of coverage provisions contained in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). That Act requires employers with 20 or more employees to continue to make available group health insurance to former employees and their dependents. Workers who are laid-off or work reduced hours would be eligible to participate for up to 18 months, and the dependents of deceased workers or a former spouse of a divorced worker for up to 36 months.

COBRA does not require the employer to continue paying premium contributions for former workers. Instead, the qualifying former employee or dependent may be required to pay up to 102 percent of the premium. Nevertheless, many in the small business community complain that complying with the COBRA requirements would be a costly administrative burden. It is also perceived as another government regulation obstacles that only intimidates and discourages small firms from offering health benefits coverage.

Mr. Fredric Rohm, testifying on behalf of the U.S. Chamber of Commerce, observed: "Simply complying with COBRA is an admin-

istrative burden for many companies. Moreover, the likelihood that those individuals who are the most frequent users of health care coverage will be the most likely to continue that coverage, with the commensurate increase in insurance premiums due to the adverse selection, belies the claim that COBRA involves no cost to employers."

Regulatory Obstacles to Pooling Arrangements

There are a number of government regulations affecting Multiple Employer Trusts (METs) and other industry pooling arrangements which discourage the formation of such associations to provide group health insurance and other employee benefits, and impede their ability to self-insure.

ERISA regulations, for example, require that all businesses joined under one association be of a similar nature, i.e., have a "commonality of business interests." This has served to preclude small firms from forming associations for the purpose of self-insuring.

Similarly, regulations governing Voluntary Employee Benefit Associations (VEBAs), also known as 501(c)(9) plans, require a high level of homogeneity among members of the association. As Mr. John Polk, director of the Council of Smaller Enterprises (COSE), testified, "These VEBA regulations make it administratively impossible for COSE to self-insure or self-administer our own programs because of the incredible reporting requirements that VEBA regulations impose on groups like ours."

In addition, in 1981, IRS began to disallow any association-sponsored MET plan if the membership of the association was wider than one metropolitan area. This year, IRS agreed to broaden the definition to allow state-wide membership, but even that is too restrictive, according to committee witnesses.

Mr. Frederick Hunt, president of the Society of Professional Benefit Administrators, testified that, "The IRS has . . . arbitrarily discriminated against association-sponsored plans, with the admitted intent of discouraging such plans . . . (because) they don't think associations should be in the insurance business."

Hunt also pointed out a further regulatory impediment caused by the Deficit Reduction Act of 1984 (DEFRA), which imposed limits on the amount of money held by a VEBA in reserve. These reserves are typically held for catastrophic claims or a shift in the workforce or new benefits. As Hunt explained, the Department of the Treasury felt that employers were keeping too much money in their VEBA reserves, and thus imposed limits and documentation requirements. These regulations act as a disincentive for small businesses to form or join a self-funded association plan, since they would not want to take the risk without prefunding adequate reserves.

3. AVAILABILITY OF INSURANCE PRODUCT

In addition to the cost factor, some witnesses, principally Swain of SBA and Polk of COSE, reported that the lack of availability of health insurance plans is a critical problem for very small businesses. As Mr. Polk stated:

> The major problem of access to the health care system for small companies exists at the lowest level of the marketplace, and the most fragile and volatile . . . the very smallest companies. Most carriers will write small group coverage down to companies with 25 workers; some will write down to 10 employees; but few carriers outside of Blue Cross/Blue Shield plans will write under ten. *Nobody* likes the "onesies and twosies," and their need is the greatest of all.

Polk also noted the difficulty that even associations of small businesses have in obtaining insurance coverage. He stated that when he tried to interest the nation's top insurance carriers in COSE's $50 million business several years ago, none of them made a proposal.

Insurers avoid small group plans because of their instability. A MET or other association is still made up of volatile small businesses, and thus will also experience substantial turnover and problems of adverse selection common to small firms.

There is also little incentive for insurance brokers to market health plans to small businesses. It is obviously far less profitable for the broker to sell a policy to a small firm, or a group of small firms, than to a large business. Insurers also are uncomfortable with the lack of data on the performance of the small employer market.

Another factor, as noted previously, is that insurers are prohibited by state mandated benefit laws from marketing a less comprehensive and more affordable basic health benefits package that would meet the needs of the small employer.

IV. OPTIONS TO EXPAND COVERAGE

The 37 million uninsured Americans are a heterogeneous group, consisting mainly of low-income workers and their dependents, the nonworking poor, and the medically uninsurable. The dimensions of the health insurance problem are underscored by the varied and complex factors that contribute to the rapidly growing uninsured population. Witnesses who appeared before the Committee generally agreed that the multiple factors responsible for the erosion of health insurance coverage in this country require multiple strategies to address the problem. No single solution, other than a system of national health insurance, can possibly meet the diverse needs of the uninsured and accommodate the unique problems of the small business employer.

The Committee's hearings explored various strategies in the public and private sector to expand health insurance coverage. These different strategies are targeted to the three main categories of the uninsured population: (1) the employed uninsured; (2) the nonworking poor and near poor; and (3) the medically uninsurable.

The alternative options for the employed uninsured include tax incentives, pooling arrangements, and a Medicaid buy-in program for low-income workers; for the nonworking poor and near poor, expansion of Medicaid eligibility and subsidized vouchers or tax credits; and for the medically uninsurable, subsidized state risk pools. Some of these strategies may be targeted at more than one category of the uninsured population.

Other options suggested by Committee witnesses include creation of managed health care systems and other cost containment plans, and educational or information referral programs to inform small business owners about the availability of affordable insurance products.

The options for expanding health insurance coverage among the working uninsured are viewed as alternatives to a federal program of mandated health benefits, as proposed in S. 1265. That bill requires all employers to provide a basic minimum package of health insurance for workers employed at least 17.5 hours per week. A summary of the mandated benefits proposal is also included in the following discussion of alternative strategies to expand health insurance coverage.

A. Tax Incentives

The Tax Reform Act of 1986 allowed for the first time a 25 percent deduction for health insurance premiums for the self-employed (owners of unincorporated businesses), provided they extend similar coverage to their employees.

Witnesses who appeared before the Committee all endorsed a full 100 percent deduction for the self-employed as a matter of funda-

mental equity, and as a means of encouraging these business owners (primarily sole proprietors and partners) to provide health insurance coverage for themselves and their employees.

As Mr. John Motley of the National Federation of Independent Business (NFIB) stated in his testimony:

> Tax incentives for health insurance have encouraged the spread of private coverage, protecting people from financial hardship and the public from carrying their burden. . . . Despite this strong commitment to encourage businesses to provide health insurance through tax incentives, small unincorporated business owners have never been afforded the same privilege as their corporate counterparts.

While supporting a full health premium tax deduction for the self-employed, Motley also pointed out that income tax deductions are an ineffective incentive for new businesses and firms with only marginal profitability. He recommended a credit against payroll taxes as a more viable incentive to expand health care coverage among small businesses.

The Chairman has introduced legislation, H.R. 3065, to raise the income tax deduction to 100 percent for health insurance premium costs of self-employed individuals, effective January 1, 1987, and to make the deduction permanent.

According to the Joint Committee on Taxation, the revenue loss from a permanent 100 percent deduction, effective January 1, 1988, would be $500 million in Fiscal Year 1988, $900 million in Fiscal Year 1989, and $1.3 billion in Fiscal Year 1990.

B. Industry Pooling Arrangements

The principal strategy designed to encourage small employers to provide health benefits for their employees involves the formation of industry pooling arrangements, such as Multiple Employer Trusts (METs).

Pooling arrangments are designed to standardize a health insurance policy and centralize administration so as to achieve economies of scale and rating stability, and thus reduce costs. They may be established on an industry or on a geographic basis. Some states are also experimenting with the formation of pools based on an affinity group, such as an ethnic community.

The forerunner of such pooling arrangements are the Taft-Hartley trusts, collectively bargained labor-management trusts formed to run pension funds and later expanded to welfare funds for health coverage for unionized workers. These are commonly called Multi-Employer Plans, and are regulated by the Employee Retirement Income Security Act (ERISA), which pre-empts state regulation of employer benefit plans, except those regulated by state insurance laws.

Multiple Employer Trusts (METs) refer to industry pooling arrangements that are not formed under collective bargaining agreements. These pools may be formed by an insurer, broker, or third-party administrator, and may be offered through local chambers of commerce, trade or professional associations, or other business groups. METs are not ERISA plans and therefore are subject to state regulation, unless they are self-insured. The primary impact of state regulation is that the plans must include any benefits specifically mandated by state law, and they are subject to state taxes

on premiums. METs that are self-insured and meet certain qualifications are classified by the Department of Labor as Multiple Employer Welfare Arrangements (MEWAs) and are placed under ERISA regulation.

Mr. John Polk, director of COSE, one of the largest and best known METs in the country, testified on his experience in directing that MET and the problems he has encountered. More than 4,500 of COSE's 7,200 member companies purchase health insurance coverage through one of eight plans sponsored by the organization. Polk stated that those member companies save about 35 percent over the cost of comparable coverage available to nonmember firms. Those cost savings are a combined function of the MET's size and of the efficiencies realized by centralized administration for all sponsored plans.

Polk also pointed out, however, that COSE's health insurance costs are still high compared to what large businesses pay due to various regulatory restrictions:

> But even with those efficiencies, the costs of our plans average about 40 percent higher than the cost of the average large-employer plan. That cost differential is not a function of the marketplace: mostly, it's a function of regulatory impediments which limit COSE's flexibility and power in the marketplace.

The regulatory impediments that Polk referred to are ERISA restrictions which make it administratively unfeasible to self-insure or self-administer, and state mandated benefits. Polk emphasized that "both market-related and regulatory factors make it extremely difficult for small companies to design and purchase benefit plans in the most efficient possible way" by combining their buying power through a MET or other association.

According to Polk and other witnesses, the regulatory obstacles that discourage the formation of pooling mechanisms for small employers could be addressed in large part by amending ERISA in two ways: (1) to exempt all insured plans from state regulation (i.e., mandated benefit laws); and (2) to allow all association plans to self-insure, rather than only those composed of businesses of a similar nature.

The market factors which result in relatively high health care costs in such pooling arrangements include adverse selection, high marketing costs, low participation and high worker turnover. Even the largest groups may still face problems of instability and high medical spending because of these factors.

Ms. Gail Wilensky of Project HOPE suggested in her testimony that the adverse selection problem could be addressed by allowing employees with a high risk of needing medical care to enroll in a subsidized risk pool for the medically uninsurable, (see page 32). As Wilensky observed, "The threat of adverse selection has been the Achilles heel of METs in the past, and the presence of a high risk pool for the medically uninsurable may be just the safety valve that is needed for the small employer community."

One possible pooling strategy to help small employers with high worker turnover involves the development of an administrative mechanism similar to the Taft-Hartley trust to serve as the holder of insurance. As Wilensky explained in her testimony:

> The Taft-Hartley Trust was developed for unionized workers in high labor turnover industries and acts as the "holder" of the workers' health and welfare policies.

Since the Trust is the holder of the health and pension plan, the worker does not lose the plan as he moves from job to job. A similar arrangement could be developed for nonunionized workers who change jobs frequently, thus making it easier for the employers to contribute and more likely for insurance to be attractive to the worker.

Under the Taft-Hartley Trust mechanism, employers pay into the trust on the basis of the number of hours the employees work. Another advantage of adopting a similar mechanism for a high turnover workforce is that it would allow workers to bank their hours in order to maintain health insurance coverage during periods of low employment.

Removal of government regulatory obstacles, in conjunction with the expansion of risk pools and new trust mechanisms to deal with the problems of adverse selection and high turnover, could have a significant impact on the formation of METs or other pooling arrangements for small businesses.

If these strategies do not effectively expand health care coverage among the employed uninsured by encouraging small businesses to form pooling mechanisms, some type of subsidy might be needed. In general, this could take the form of tax credits or grants to the employer, or direct subsidies to the pool paid by insurers, employers or other sources. However, the Committee's witnesses agreed that the strategies discussed above that do not involve direct subsidies should be implemented first.

C. Subsidized Risk Pools

Subsidized state risk pools are now being used as a means of providing health insurance to those who have been denied insurance from private carriers because of a preexisting medical condition.

Such risk pools have been established in 15 states to sell insurance, generally at a subsidized rate, to individuals who are medically uninsurable. The health insurance plans usually require the participants to pay high premiums and cost sharing provisions, such as high deductibles and copayments. The premiums are not expected to finance the plan since the participants are all poor health risks, and thus the health care expenditures of the plan are greater than those of other insured groups. The question, therefore, is how to finance the underwriting losses of the risk pool.

Most states require the insurance carriers in their state to participate in the pool. Any underwriting losses are spread among health insurers in the state and, in some cases, among employers who fully insure their health benefit plans.

Risk pools are generally funded by a tax on insurers based on their share of the state insurance market. A tax could also be imposed on employers, hospitals, or third party payers. However, employers who self-insure cannot be required to participate in the risk pool because of the ERISA preemption of state law. In some states, that means only about one-half of the insurance plans are shouldering the whole risk.

In order to provide more broad-based funding of state risk pools, legislations has been proposed that would enable states to tax self-insured health plans to underwrite state risk pools, and to require that all employers with 20 or more employees underwrite such funds. Such legislation, introduced by Representative Stark, was in-

cluded in the House-passed version of the Omnibus Budget Reconciliation Act for FY 1988 (H.R. 3545), but was dropped by the conference committee.

Some of the witnesses emphasized the importance of assuring a broad-based financing of state risk pools. Ms. Karen Williams of the Health Insurance Association of America, for example, testified that "While insurers support the concept of high risk pools for those who otherwise are uninsurable, we cannot do so without more broadly based financing of the losses of such pools including general revenues, losses borne by all employers or other mechanisms."

Similarly, Ms. Wilensky stated that the most appropriate way to finance the loss of a risk pool is to use the broadest possible tax base, such as income tax surcharge, a portion of a sales tax, a value-added tax, or a specific excise tax.

In addition to medically uninsurable individuals, risk pools could also be directed toward the general low-income working population. Such an approach would enable small employers to share the risk involved in providing health insurance, and provide a mechanism for subsidizing the purchase of insurance by low-income workers.

State risk pools could also be used to enroll high-risk uninsurable employees whose pre-existing medical condition prevents their employer from obtaining group coverage. Under this plan, as described in a pilot program being implemented by the State of Wisconsin, the high-risk employee would be enrolled in the risk pool at a cost to the employee no greater than what he would pay if enrolled in the employer's group plan. In return, the employer would be required to enroll all the rest of its employees in a group plan, and contribute to the risk pool the same amount it contributes toward the coverage of the remainder of its employees.

The main problem with state risk pools for the medically uninsurable is that unless the premium is heavily subsidized and the limits on out-of-pocket expenses are relatively low, few individuals would be able to purchase such insurance. Generally, coverage through a risk pool is likely to be more expensive than through an individual policy, with premiums ranging from 125 to 200 percent of comparable standard coverage. Consequently, a pool for the medically uninsurable will affect only a small percentage of the uninsured population. But, as Wilensky noted, subsidized risk pools are likely to be an important part of any incentive-based strategy to expand coverage among the employed uninsured because they will remove the element of risk for small employers.

D. Medicaid-Related Strategies

The principal policy option to extend health care coverage to the poor unemployed and to low-income workers involves expanding the current Medicaid program. There are two Medicaid-related strategies: (1) expand Medicaid eligibility in a variety of ways to cover significantly more of the poor; and (2) allow the near poor and low-income workers to buy into Medicaid with premiums adjusted on a sliding scale based on income.

Medicaid is a state-based public insurance program for the poor, with eligibility tied to the receipt of cash assistance from a federal

or state welfare program. Most Medicaid recipients qualify for coverage when they receive benefits through the federal income assistance program, Aid to Families with Dependent Children (AFDC). Levels of qualifying income under AFDC are determined by the states. In 1986, the average income eligibility level set by the states was less than 48 percent of the federal poverty standard. Consequently, the Medicaid program now covers less than 40 percent of the nonelderly poor population, compared to nearly 65 percent 10 years ago.

There are a variety of options for expanding Medicaid to cover more, if not all, of the poor. The most comprehensive proposal is to set a minimum federal standard for income eligibility equal to the poverty level. Variations in the target population and in the income eligibility levels, such as 60 or 70 percent of poverty, could be adopted. According to Chollet, extending Medicaid coverage to all persons below the poverty level would have reduced the uninsured population by 42 percent in 1985. A more limited option, extending Medicaid eligibility to all children in poverty and their parents, would have reduced the number of uninsured by 19 percent.

In her testimony, Chollet noted that although federal law allows the states to extend Medicaid coverage to financially eligible children under age 18, only about 20 states currently do so. However, the states are now required under the 1984 Deficit Reduction Act (DEFRA) to extend coverage to financially eligible children under age 5, and gradually to all financially eligible children under age 18 by 2001. Chollet suggested the option of extending Medicaid coverage to these children immediately and raising the states' qualifying income levels to the federal poverty standard.

In addition, Chollet testified that states may "extend Medicaid to parents in intact families that may not qualify for AFDC benefits, if they financially qualify and if the primary family worker (typically the father) is unemployed." A second option she suggested is to make this coverage mandatory, and to raise the qualifying income to the federal poverty level.

Chollet described the effect of these two options for expanding Medicaid eligibility as follows:

> Extending Medicaid coverage to all poor children would have covered an additional 4.3 million children, 38 percent of all uninsured children in 1985. Extending Medicaid coverage to adults in below-poverty families with dependent children would have increased coverage by 2.4 million people. If Medicaid had covered these two populations in 1985, the total Medicaid population would have increased by approximately one-third over its actual 1985 level.

In addition to expanding Medicaid eligibility for the poor, an income-related Medicaid buy-in program is frequently mentioned as an option to extend coverage to uninsured workers who are below the poverty line but whose incomes are above the Medicaid eligibility levels. Specifically, such a program might allow all adults in below poverty families without dependent children, and all persons within 200 percent of the federal poverty line to buy Medicaid coverage. Premiums would be adjusted on a sliding scale based on income. This strategy would provide health insurance to low-income workers while reducing the disincentives whereby

workers whose incomes exceed the eligibility level lose all Medicaid support.

According to Chollet, the individuals that would be served by such a Medicaid buy-in program "represent a larger percentage of the uninsured population and potentially a much greater expansion of the Medicaid program. These populations together totaled nearly 15 million in 1985, or 42 percent of the uninsured. Including the near poor as well as the entire poor population without insurance coverage would have approximately doubled the population participating in Medicaid in 1985."

The problem with this option is that fully three-quarters of all uninsured workers earn less than $10,000. Consequently, the population to be served by a Medicaid buy-in—poor and near-poor uninsured—would require a substantial subsidy to afford coverage.

Chollet stated that the average cost of Medicaid coverage for this population might be comparable to the cost of comprehensive private insurance:

> The potential Medicaid premium for a family of two adults and two children . . . might have totaled $2,626, or $219 per month (in fiscal year 1985). For families with near-poverty income, this cost might be prohibitive. . . . (It) would have totaled almost 16 percent of gross family income for people living at 150 percent of the federal poverty standard.
>
> . . . If Medicaid were to finance 70 percent of the premium for the above two-adult family of four, the family's net premium payment for coverage would equal $66 per month—approximately 5 percent of gross family income at 150 percent of poverty.

A Medicaid buy-in strategy has also been proposed for small employers directly. Senator Chafee, for example, has introduced legislation (S. 1139) that would allow businesses with no more than 25 employees to purchase Medicaid coverage for their workers. Such firms would be eligible to buy into Medicaid if they are determined by the state to be unable to provide adequate health insurance coverage to their employees at a reasonable cost.

Similarly, Arizona is implementing a pilot project in which small employers with less than 25 employees are allowed to buy into Medicaid. The state's indigent care program has designed a program to market prepaid health plans to small businesses. Dr. Leonard Kirschner, director of the Arizona Health Care Cost Containment System, described the program in his testimony:

> Unlike traditional insurance carriers, no industries are excluded from coverage, and underwriting restrictions are minimal. The goal in the development of the program has been to protect the participating health plans from undue financial risk, while still making coverage available to as many employees in need as possible. To protect against the problem of adverse selection, there is a 50 percent minimum group participation required; . . . Employer contributions to the premium payment will be strongly encouraged but not required.

E. Subsidized Voucher/Tax Credit

Another option to expand coverage among the low-income uninsured is to provide them a direct state government subsidy toward the purchase of adequate health insurance. The subsidy could take the form of a tax credit or a redeemable voucher, and could be made available to all those uninsured whose incomes are below some threshold level, such as 200 percent of the federal poverty standard.

In a pilot project developed in Wisconsin, for example, low-income uninsured individuals would receive monthly vouchers equal to the difference between what they could afford to pay (according to an income-based sliding scale) and the lowest cost health insurance plan available. Individuals could either shop around for coverage under a plan that best meets their needs, or turn over the vouchers to their employer for the purpose of obtaining group coverage. The voucher-holder would pay any additional premium required. In the case of group coverage, any additional premium cost could be shared by the employer and the employee based on some formula.

Under this plan, the state would set the subsidy schedule and eligibility criteria, redeem vouchers, and conduct general oversight of the program

The success of such a strategy in expanding health care coverage to the low-income uninsured depends on the size of the subsidy and its structure. Obviously, the variations are limitless. To illustrate, the subsidy could pay 100 percent of the premium if the individual's income is below the poverty line; 67 percent if the income is no more than 150 percent of the poverty level; and 50 percent if the income is between 150 and 200 percent of poverty.

In terms of how a premium subsidy is financed, the consensus among those states that are implementing demonstration projects of this kind is to fund the subsidy through general revenues.

Mr. Larry Thompson, director of Project Access in the State of Washington, for example, testified that "the responsibility for premium subsidy should be spread across the widest possible base." He noted that during development of the Washington pilot project, consideration was given to various proposals involving taxing health care providers, businesses, cigarette smokers, etc. But in the end, the state decided to subsidize premiums through general revenues. As Thompson observed, "the legislature recognized that care for the uninsured is a general government or taxpayer responsibility."

F. Cost Containment Strategies

The continued rise in the cost of health care has encouraged businesses and insurers to implement various strategies to control escalating health costs. These include redesigning benefit plans to increase deductibles and copayments, establish utilization-reviews, require second surgical opinions, and other measures to control costs and utilization of health care.

In addition, a number of states are exploring the feasibility of creating an affordable insurance program for low-income workers and small businesses. Most such plans focus on firms with fewer than 10 employees, the majority of whom have incomes less than 200% of the poverty level. A major component of such plans to improve the insurance product is the use of managed health care systems.

In the Washington pilot project, for example, the managed care system uses existing Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and other group health care providers in a state-subsidized plan for low-income workers

that is designed to control health care access and utilization. An independent agency is established and directed to design a health care plan emphasizing preventive and primary health care, with a premium structure based on income, and a structure of nominal co-payments designed to discourage inappropriate use of health care services.

Other cost control mechanisms include establishing hospital utilization review boards, or requiring enrollees to select a primary care physician to act as gatekeeper to control hospital admission and use of inpatient services.

G. Catastrophic Insurance Plan

Another proposal that addresses the lack of an affordable insurance product for many of the uninsured is to establish a catastrophic health plan that will provide minimal coverage at a reasonable cost. The basic features of such a plan would include low premiums, very high deductibles, and coverage of specified core benefits.

A catastrophic plan would also have a coinsurance feature, capped by an overall "stop-loss" or limit on out-of-pocket expenses. The stop-loss and/or the deductible could vary according to the individual's ability to pay. The maximum levels might be a $750 deductible, for example, and a $1,750 stop-loss.

The advantages of a catastrophic insurance plan are that the costs would be limited because of the high deductible and stop-loss levels, and it would protect individuals from the financial ruin of catastrophic illness.

The disadvantages are that the high deductible would impose a barrier to access for routine and preventive care, and that such a catastrophic plan would not be a feasible option for the very low-income uninsured.

Mr. Swain of SBA recommended development of a catastrophic plan to help reduce the uninsured population. He emphasized the importance of reducing the price of group health insurance, and contended that government mandated benefits "would be unnecessary if an affordable catastrophic plan were developed and marketed to employers because they would voluntarily purchase such a plan."

A catastrophic health care plan designed to protect elderly and disabled Medicare beneficiaries was passed by both houses of Congress in 1987 and is pending in conference committee. The bill (H.R. 2470) provides coverage of unlimited hospital stays and places an overall limit of about $1,800 on the amount Medicare beneficiaries must pay for covered services. The cost of the expanded benefits would be financed by increasing the monthly Medicare premium, and by creating a new supplemental premium that is adjusted according to income.

H. Educational Efforts

Some states are developing projects to provide insurance referral services to assist small firms in obtaining health insurance coverage. Mr. David Helms, director of the Robert Wood Johnson Foundation health care grant program, testified that United Way of San

Francisco has been awarded a grant to "explore the feasibility of creating a service that provides small employers with information on the types of health plans currently available, their cost, benefit coverage, and how to enroll in the health plans."

Similarly, Swain indicated that SBA can disseminate information through its district offices to help small businesses obtain health insurance coverage and to assist them in cost containment measures.

These efforts are intended to overcome the basic lack of information and understanding among most small business owners regarding available health care plans and how to obtain insurance coverage at a reasonable cost.

I. Mandated Employee Health Benefits

The principal employer-based strategy to expand health insurance coverage is to require that all employers provide health benefits for their workers. The mandated health benefits bill introduced by Senator Kennedy (S. 1265, and Representative Waxman's companion bill, H.R. 2508) requires employers to provide a basic minimum package of health insurance coverage for employees who work at least 17.5 hours per week. The legislation would cover approximately 24 million workers and their dependents, or two-thirds of the uninsured population.

Employers are required to pay at least 80 percent of the premium cost. In the case of low-income workers earning $4.19 an hour or less, the employer would pay the entire premium. Employees are required to participate in the health insurance plan.

The total annual premium cost for newly-covered workers has been estimated at $708 for individuals and $1,798 for family coverage. According to the Congressional Budget Office, the cost of the program for employers required to purchase new policies would be about $22 billion, or $900 per employee. This amount represents a 12 percent increase in these employees' wages.

In order to reduce costs for small employers, the bill establishes a structured choice system in six to eight geographical regions designated by the Secretary of Health and Human Services. Small firms would be aggregated into larger insurance units to obtain the benefits of community rating, group purchasing power and lower administrative costs. The bill establishes a competitive system to select large regional health insurance contractors who will offer a selection of standard plans.

Businesses less than 2 years old with less than 10 employees would be permitted to provide as an alternative only catastrophic protection for their workers.

V. RECOMMENDATIONS

The public policy debate on problems associated with gaps in health insurance coverage has focused primarily on the mandated benefits bill that would require all businesses to provide a minimum health benefit package for their employees. The bill has generated considerable controversy within the business community, and is strongly opposed by small businesses, principally on grounds that they could not afford the cost and would be forced to lay off workers.

The fact is that, at this time, there does not appear to be any political consensus developing around the mandated benefits proposal, or even a modified version of the legislation under consideration. Given the controversy surrounding the mandated benefits approach, and the broad range of alternative strategies that are available to expand health insurance coverage, it does not appear warranted to pursue the mandated benefits approach. However, alternative options should be fully explored and implemented as fast as possible in order to deal with increasing gaps in health insurance coverage among working Americans.

The lack of health insurance coverage for 37 million people is clearly a serious public policy concern—and one that should be addressed through different strategies targeted at specific segments of the uninsured population. There are a broad range of alternative options available. Fifteen state pilot programs to broaden insurance coverage are now being implemented. Other alternatives have been proposed in pending legislation. Congress should fully consider these alternatives and try to find a consensus on those strategies that can quickly begin to fill the gaps in the nation's health insurance system.

This report recommends strategies targeted at two specific categories of the uninsured population: The self-employed business owner and very small businesses, those with less than 25 employees. These include (1) a full tax deduction for the premium costs of the self-employed; (2) changes in existing regulations to encourage small businesses to form pooling arrangements; and (3) broad-based funding of state risk pools by allowing states to tax self-insured plans.

These alternative proposals are aimed primarily at removing regulations and disincentives that serve to increase health insurance costs and discourage small employers from providing coverage. Other strategies now being tested by the states, such as subsidized vouchers for low-income workers, Medicaid buy-ins, and cost containment efforts, should be studied and evaluated at the appropriate time to determine if they should be implemented in some form at the federal level. Still other strategies to expand coverage depend on the insurers and health care providers to design less

costly benefit plans and delivery systems that are affordable to small businesses.

The recommendations follow:

A. Full Tax Deduction for Self-Employed

One tax incentive that would encourage the self-employed to provide health insurance coverage is to provide a full income tax deduction on their health insurance premiums. Chairman LaFalce has introduced legislation (H.R. 3065) to correct the inequity in the tax code under which unincorporated business owners can now deduct only 25 percent of their health premiums, while their corporate counterparts are entitled to a full tax deduction.

H.R. 3065 would raise the deduction to 100 percent for self-employed individuals, effective January 1, 1987, and would make the deduction permanent. As in current law, the deduction would be allowed only if the self-employed individual offers comparable health benefits to his or her employees. This tax deduction would provide an important incentive for the self-employed, primarily sole proprietors and partners, to provide health insurance coverage for themselves and their employees. Providing such a tax incentive is more equitable and ultimately more cost effective in the long run than the present system which increases costs to the government and finally to the people to pay the costs of uncompensated care.

B. Encourage Pooling Arrangements

Industry pooling arrangements, such as Multiple Employer Trusts (METs), are an essential mechanism that small firms with less than 25 employees must have in order to reduce health insurance costs by spreading the risk more broadly. According to the committee's witnesses, there are certain obstacles created by government regulation that discourage the formation of such associations to provide group health insurance. These principally include the Employee Retirement Income Security Act (ERISA) and IRS regulations governing employee benefits associations.

The Committee, of course, defers to the expertise of the relevant committees of legislative jurisdiction on these issues, and urges them to explore possible solutions to government regulations that impede the formation of pooling arrangements by small firms. In particular, it is recommended that ERISA be amended to permit METs and other small group associations to self-insure, and thus be exempt from state mandated benefit laws.

C. Subsidized Risk Pools

Fifteen states have established subsidized risk pools to provide insurance coverage for the medically-uninsurable and those who do not have access to employer-based coverage. States can only require state-regulated health insurance plans to participate in the pools; they cannot tax self-insured plans because of the ERISA preemption of state law.

In order to facilitate the establishment and viability of these risk pools, it is recommended that Congress enact legislation to require all employers with more than 20 employees to participate in a state

risk pool. Such legislation, introduced by Representative Stark, was included in the House version of the Omnibus Budget Reconciliation bill for FY 1988, but was not included in the final version signed by the President.

This proposal would also help small businesses to form pooling arrangements. It would allow a small firm to enroll a high-risk employee in the state risk pool, and thus avoid denial of coverage in a small group association or higher premium costs because of that employee.

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